UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION REQUEST FORM

REVATIO (sildenafil citrate)

Patient name:_____Medicaid or SS#_____

Physician Name:_____ Contact person:_____

Phone#:_____Ext. and opt._____Fax#_____

Pharmacy_____Pharmacy Phone#:_____

All information to be legible, complete and correct or form will be returned

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FAX DOCUMENTATION FROM PROGRESS NOTES OR IN LETTER OF MEDICAL NECESSITY

INFORMATION:

This medication requires a prior authorization through the prior authorization department and it is then forwarded to another department for override of the amount given each month.

CRITERIA:

- Patient must have documented Pulmonary Hypertension

AUTHORIZATION:

1 year

RE-AUTHORIZATION:

An updated letter or progress note indicating improvement or maintenence with the medication.

8/8/6